Iowa Department of Human Services

Kim Reynolds
Governor

Adam Gregg
Lt. Governor

Jerry R. Foxhoven
Director

INFORMATIONAL LETTER NO.1901- MC-FFS

DATE: April 23, 2018

TO: All Iowa Medicaid Providers (Excluding Indian Health Service)

APPLIES TO: Managed Care (MC) and Fee-for-Service (FFS)

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

RE: Emergency Room (ER) Visits and Emergency Diagnosis Codes

EFFECTIVE: July 1, 2018

Informational Letter 1758-MC-FFS[1] reminded providers about Medicaid's 2011 payment policy regarding services performed in the ER. The policy applies to payments made under FFS as well as MC. The conditions for payment of ER claims are described in the Hospital Provider Manual[2], beginning on page 49. This includes a reference to the list of diagnosis codes[3] that are automatically recognized as emergent in nature. If a claim for an emergent service does not contain a diagnosis from that list, payment may be reduced as described in the Provider Manual.

The diagnosis codes listed on the claim should typically reflect whether the situation was an emergency medical condition. However, this may not always be the case when considering the fuller context of the underlying medical record. The process descriptions below indicate how providers can request reconsideration of ER claims if the payment does not match the full context of the specific encounter in the ER.

FFS: The process for further consideration of a reduced payment up to the emergent level is to send in a Provider Inquiry[4] along with related documentation supporting why the claim should be considered emergent in nature. The Provider Inquiry form and submission process is described in the General Program Policies[5] section of the Provider Manual on page 44. When such an inquiry is received, it is reviewed by Medical Services personnel for a potential payment adjustment to the full, emergent rate. Similarly, in any case where a claim is paid at the full amount but the service was not actually considered emergent (such as the presence of an emergent diagnosis that is "historical" and not directly related to the date of service on the claim); providers would be expected to pursue corrections to those claims as well.

UnitedHealthcare Plan of the River Valley, Inc. (UnitedHealthcare) has two processes in place for providers to request review of an ER claim not billed with an emergent diagnosis code for additional reimbursement:

1. If the ER claim is not billed with a defined emergent diagnosis code but meets the Emergency Medical Treatment and Labor Act (EMTALA) prudent layperson standards of an emergency

[1] https://dhs.iowa.gov/sites/default/files/1758-MC-FFS_EmergencyRoomVisits-Reimbursement-Clarification.pdf
[2] http://dhs.iowa.gov/sites/default/files/AHosp.pdf
[3] https://dhs.iowa.gov/sites/default/files/ICD-10_Emergency_Dx_1.pdf
[4] http://dhs.iowa.gov/sites/default/files/470-3744.pdf
[5] http://dhs.iowa.gov/sites/default/files/All-I.pdf

medical condition, the member, member's authorized representative or provider on behalf of the member may submit an appeal to UnitedHealthcare (typically by mail, fax or calling into customer service). Documentation or an explanation of what presenting symptoms constituted an emergency medical condition in the judgment of a prudent layperson must be provided. Additional information on submitting appeals can be found in the UnitedHealthcare Care Provider Manual[6], Chapter 4: Grievances, Appeals and State Fair Hearings.

2. UnitedHealthcare has a Reimbursement Guidelines for Non-Emergent ER Visits[7] bulletin available on the UnitedHealthcare website that outlines the process for providers to request a claim reconsideration to receive reimbursement at 75 percent rather than 50 percent, if the member was referred to the ER.

Amerigroup Iowa, Inc. (Amerigroup): The process for review of ER claims that did not have an emergent diagnosis code can follow one of the options below.

Amerigroup offers two different claim appeal processes, outlined in further detail in the Amerigroup Provider Manual[8]:

1. The Prospective Review Process is available for emergency department (ED) claims that do not have a defined emergent ICD-10 diagnosis code billed on the claim form. This process allows providers and facilities to have their claims and medical records reviewed for medical emergency determination prior to the claim being processed. The provider or facility may attach the complete ED medical record to the claim upon initial claim submission. The claim and records will be pended for clinical review to determine if the services provided are a valid emergency medical condition.

2. The Retro-Prospective Review Process is available for claims that have been filed and processed as not meeting emergency department criteria. This process allows providers and facilities to have their claims and medical records reviewed for medical emergency determination post claims adjudication. Facilities that have filed claims which have been processed and determined to be nonemergency may appeal the denial by using the appeal process. This process is outlined in the Amerigroup manual[9]. Timely filing guidelines will apply.

Please note the existing emergency diagnosis list is under a comprehensive review to remove some codes that are not actually considered emergent or no longer a valid diagnosis code and will be updated to reflect that change effective for claims processed on or after July 1, 2018. In addition, the timing of regular updates to the comprehensive list is also changing, from the current quarterly basis to annually. As such, the next regular update will be made on January 1, 2019, and annually thereafter.

The IME appreciates your continued partnership as we work to improve the claim processing service quality and accuracy. If you have questions, please contact the IME Provider Services Unit at 1-800-338-7909 or email at imeproviderservices@dhs.state.ia.us.

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[6] https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/provider-admin-manual/IA-Admin/IA_UnitedHealthcare_Provider_Manual.pdf
[7] https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/Bulletins/IA-Bulletins/IA-Reimbursement-Guidelines-for-Non-Emergent-ER-Visits.pdf
[8] https://providers.amerigroup.com/ProviderDocuments/IAIA_ProviderManual.pdf
[9] https://providers.amerigroup.com/ia/Pages/ia.aspx